Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Ground and Air Ambulance Medical Transportation

Billing Instructions

[Chapter 388-546 WAC]

October 2003

About this publication

This billing instruction is designed to help ambulance providers and their staff understand Medical Assistance Administration (MAA) regulations and requirements necessary for reporting accurate and complete claim information.

This publication supersedes all previous MAA Ground/Air Ambulance Medical Transportation Billing Instructions.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

> **Provider Enrollment Unit**
> (866) 545-0544

Where do I send my claims?

> Division of Program Support
> PO Box 9248
> Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

> **Go to MAA's web site at:**
> **http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.**

How do I obtain a limitation extension?

> Copy and complete the Limitation Extension Request Form (included in this billing instruction) and fax to:
>
> (360) 586-1471

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

> Medical Assistance Customer Service Center
> (800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

> Coordination of Benefits Section
> (800) 562-6136

Internet Billing?

> http://maa.dshs.wa.gov/ecs

Access Issues, Broker Transportation, Client Complaints, Healthy Options Enrollment, Disenrollment, Exemptions?

> Medical Assistance Customer Service Center (MACSC) (Clients Only)
> (800) 562-3022

Eligibility for Children's Medical, Healthy Options and Basic Health Plus?

> Medical Eligibility Determination Services (MEDS)
> (800) 204-6429

Definitions

This section defines terms and acronyms used within these billing instructions.

Advanced Life Support (ALS) - Invasive emergency medical services requiring advanced medical treatment skills as defined by chapter 18.71 RCW. [RCW 18.73.030(18)]

Air Ambulance – A fixed-wing or rotary aircraft that has been inspected and licensed by the Department of Health as an ambulance.

Ambulance - A ground or air vehicle designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation. [RCW 18.73.030(4)]

Ambulance Operator – A person who owns one or more ambulances and operates them as a private business. [RCW 18.73.030(7)]

"Approved Medical Program Director" - A person who is:

- Licensed to practice medicine and surgery pursuant to chapter 18.71 RCW or osteopathic medicine and surgery pursuant to chapter 18.57 RCW;
- Qualified and knowledgeable in the administration and management of emergency care and services; and
- So certified by the department of health for a county, group of counties, or cities with populations over four hundred thousand in coordination with the recommendations of the local medical community and local emergency medical services and trauma care council. [Refer to RCW 18.71.205(4).]

Base Rate - The department's minimum allowable amount per transport, which includes allowances for emergency medical services provided, attendants, reusable supplies and equipment, hardware, stretchers, some disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage and specified disposable supplies.

Basic Life Support (BLS) - Noninvasive emergency medical services requiring basic medical treatment skills as defined in chapter 18.73 RCW. [RCW 18.73.030(17)]

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. (WAC 388-531-0050)

Chart – A summary of medical records on the individual patient.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department's economic services administration that administers social and health services at the community level.

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Department - The state Department of Social and Health Services (DSHS).

Destination/Nearest Appropriate Facility – An institution generally equipped to provide the needed hospital or skilled nursing facility care for the injury, illness, symptom, or complaint involved. In the case of a hospital, a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition.

Emergency – A service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Medical Service - Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities. [RCW 18.73.030(11)]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Ground Ambulance - A ground vehicle designed and primarily used to transport the ill and/or injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

Hospital – A facility licensed under chapter 70.41 RCW, or comparable health care facility operated by the federal government or located and licensed in another state.

Interfacility Transport – Medical transportation of a patient between recognized medical treatment facilities, requested by a licensed health care provider.

Involuntary Treatment Act (ITA) – See chapter 71.05 RCW and chapter 275-55 WAC for adults. See chapter 71.34 RCW and chapter 275-54 WAC for juveniles.

Liftoff fee - The base rate paid an air ambulance provider for transporting a client.

Loaded Mileage – Mileage in which a client is on board an ambulance.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Control – The medical authority on whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center (destination) assignment for the patient being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Non-Emergency – Any ambulance trip not meeting the criteria listed under "Emergency" in this section. This includes all scheduled runs (regardless of origin and destination) as well as transports to and from nursing facilities, physicians' clinics, and other diagnostic/treatment centers.

Paramedic - A person who:

- Has successfully completed an emergency medical technician course as described in chapter 18.73 RCW;
- Is trained under the supervision of an approved medical program director to:
  ✓ Carry out all phases of advanced cardiac life support;
  ✓ Administer drugs under written or oral authorization of an approved licensed physician;
  ✓ Administer intravenous solutions under written or oral authorization of an approved licensed physician; and
  ✓ Perform endotracheal airway management and other authorized aids to ventilation; and

● Has been examined and certified as a physician's trained mobile intensive care paramedic by the University of Washington school of medicine or the department of health.

Patient Identification Code (PIC) - An alphanumeric code which is assigned to each Medicaid client and which consists of:

a) First and middle initials (<u>or</u> a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tie breaker).

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients.

Record – Dated reports supporting claims submitted to the Washington Medical Assistance Administration (MAA) for medical services provided in a client's home, a physician's office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Remittance and Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Rotary aircraft - A helicopter.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Trauma – A major single- or multi-system injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

Usual and Customary Charge - The fee that the provider typically charges the general public for the product or service.

Waiting time - Time spent waiting for the client or some event or thing (e.g., ferry and ferry crossing) necessary to complete the transport.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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About the Program

The ambulance transportation program is part of an overall plan to provide medically necessary transportation to and from the provider of MAA covered services that is closest and most appropriate to the client's medical need. Most of the transportation MAA provides for its clients is non-emergency medical transportation. With few exceptions, non-emergency transportation is provided through a series of contracts with local transportation brokers, meaning not by ambulance. Transportation brokers are listed on MAA's website at http://maa.dshs.wa.gov and in MAA's General Information Booklet.

The following types of medical transportation are not provided through contracted brokers:

- Air Ambulance – emergency medical transportation by air;

- Ground Ambulance – transportation by ground ambulance that is either:

    ✓ Emergency medical transportation; or
    ✓ Transportation to MAA-covered medical services requiring that the client:

        ➢ Be transported by stretcher or gurney for medical or safety reasons[1]; or
        ➢ Have medical attention from trained medical personnel available en route.

Medical Necessity for Ambulance Transportation

Transportation that is provided by ambulance providers and billed to MAA must have the medical necessity of this means of transportation documented in the client's file. MAA coverage of ambulance transportation is determined based on the client's condition at the time of transport. The destination must be the closest, local provider of the medically necessary MAA-covered medical services.

MAA covers a client's transportation in an ambulance only if the client could not be safely (or legally) transported any other way. If a client could safely travel by car, van, taxi, or other means, the ambulance transport would not be medically necessary and the ambulance level of service would not be covered by MAA.

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[1] RCW 18.73.180 requires MAA to provide transportation by ground ambulance vehicle whenever the client's medical condition requires that the client be transported in the prone or supine position. Nothing prohibits ambulance providers from entering into contracts with MAA or with MAA's transportation brokers to provide non-emergent ambulance service at payment rates that are lower than typical BLS ambulance service.

State law does allow for non-emergent transportation by ground ambulance; however, this allowance applies only to clients who must be transported in the prone or supine position (for medical or safety reasons) or to clients who are likely to require medical attention en route to a diagnostic or treatment facility. Again, the client's medical condition ~~at the time of the transport~~ must present a valid medical or safety need and must be well documented.

A doctor's or a hospital's order for ambulance transportation is not sufficient to guarantee that MAA will pay for the ambulance transportation. The ambulance provider is responsible for ensuring that the medical necessity justification is both valid and well documented in the client's file.

If Medicare or another third-party denies coverage of an ambulance transport on the basis of lack of medical necessity, the provider must be prepared to demonstrate to MAA why the transport meets MAA's requirement for medical necessity. MAA's presumption in such a case is that the transport does not meet the medical necessity requirements of MAA.

Standards for Emergency Transport

In Washington State, the type and mode of emergency transportation, the urgency of transport and the destination decision are determined by certified Emergency Medical Services (EMS) and trauma personnel, in conjunction with their regional "medical control." These decisions are based on their professional judgment, consultation with emergency room physicians, and industry standards. These standards are outlined in "State of Washington Pre-hospital Trauma Triage Procedures" (available from the Department of Health), triage plans developed and implemented by the regional EMS and trauma care councils, and client care procedures and protocols developed by the regional councils.

Ambulance Transports Covered in Bundled Payments

In certain situations, ambulance transportation may be medically necessary, but it does not qualify for separate payment by MAA. This occurs when the ambulance transport is included in bundled payments to hospitals or other providers. An example of this is the transport of a client who is a registered inpatient of a hospital to another facility for a diagnostic service (e.g., a CAT scan, etc.) and the inpatient's return trip to the hospital. MAA's hospital contracts state that: "transportation services subsequent to admission and prior to discharge which are necessary to provide inpatient services under this contract are part of inpatient services." Payment for such inpatient transport is included within the hospital's Diagnosis Related Group (DRG) payment. In such a case, MAA does not reimburse the ambulance provider separately, and the ambulance provider may not bill MAA's client for the transport. The hospital is responsible for the reimbursement of the ambulance transport.

Levels of Ambulance Transport

<u>Ground Ambulance</u>

MAA reimburses for two levels of medically necessary ground ambulance transportation:

- **<u>Basic Life Support (BLS)</u>**

  A **BLS** transport is one in which the client:

  ✓ Requires and receives basic services en route, such as control of bleeding, splinting of fracture(s), treatment for shock, and cardiopulmonary resuscitation; or

  ✓ Needs to be transported in a prone or supine position, with or without medical services en route.

- **<u>Advanced Life Support (ALS)</u>**

  An **ALS** transport is one in which the client requires and receives more complex services en route, such as:

  ✓ Intravenous therapy;

  ✓ Airway intubation;

  ✓ Heart defibrillation by paramedics or other ALS-qualified personnel on-board a properly-equipped vehicle; or

  ✓ Initiation of treatment for pneumothorax conditions.

  An ALS transport is distinguished from a BLS transport by the kinds of medical interventions needed by the client and provided by a qualified crew. ALS involves invasive, emergency medical services requiring advanced treatment skills provided to the client en route.

The level of service reimbursed by MAA depends on the medical interventions needed by the client <u>and</u> provided during the transport. The medical intervention must be documented in the client's file.

<u>Air Ambulance</u>

MAA considers all air ambulance transports as ALS. Payment is based on lift-off and mileage.

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Client Eligibility

Who is eligible for MAA-paid ambulance services?

Clients presenting Medical Identification (ID) cards with the following identifiers <u>are eligible</u> for Ground/Air Ambulance Medical Transportation services:

Medical Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Medical Only
LCP - MNP	Limited Casualty Program - Medically Needy Program

☞   **Please Note:**   See next page for Managed Care clients.

Limitations

Clients presenting Medical ID cards with the following identifiers are eligible <u>for in-state transportation only</u>:

Medical Identifier	Medical Program
GA-U No Out of State Care	General Assistance-Unemployable
Detox Only	Detox
General Assistance – No Out of State Care	ADATSA
LCP-MNP – Emergency Medical Only	Limited Casualty Program – Medically Needy Program – Emergency Medical Only

Who is not eligible for MAA-paid ambulance services?

Clients presenting Medical ID cards with the following identifiers are <u>not</u> eligible for Ground/Air Ambulance Medical Transportation services:

Medical Identifier	Medical Program
Family Planning Only	Family Planning
QMB-Medicare Only	Qualified Medicare Beneficiary-Medicare Only (MAA pays only the Medicare premiums and coinsurance costs for these clients.)

Can clients who are enrolled in an MAA managed care plan receive Ground/Air Ambulance services?

Yes! Clients whose Medical ID cards have an HMO identifier in the HMO column are enrolled in an MAA managed care plan. Ground/Air Ambulance services are covered under MAA's managed care plans when the services are medically necessary. Services include, but are not limited to:

- Basic Life Support;
- Advanced Life Support; and
- Other required transportation costs, such as tolls and fares.

In addition, MAA's managed care plans cover non-emergency ambulance services for clients if the client must be carried on a stretcher or may require medical attention en route **[refer to RCW 18.73.180]**.

Please contact the managed care plan in your area to become familiar with their prior authorization and billing procedures. See http://maa.dshs.wa.gov/healthyoptions for a listing of MAA's managed care plans by county.

Clients covered by a Primary Care Case Manager (PCCM) need authorization from their PCCM. The PCCM's name and phone number is located in the bottom right-hand corner of the client's Medical ID card.

General Program Policies

General Requirements for Ambulance Providers

- Air and ground ambulances must be licensed, operated, and equipped in accordance with applicable federal, state, and local statutes, ordinances, and regulations.

- Air and ground ambulances must be staffed and operated by appropriately trained and certified personnel in accordance with applicable federal, state, and local statutes, ordinances, and regulations. Any invasive, emergency medical services required by a client during ambulance transport must be provided by properly authorized and trained personnel.

- Providers of ambulance services must provide medical justification to MAA when billing transportation claims and related services and supplies to MAA. Documentation in the client's file must include the severity and complexity of the client's condition at the time of transport.

What is included in the base rate?

The base rate includes:

- Emergency medical services;
- Costs of standing orders;
- Attendants;
- Reusable supplies and equipment;
- Hardware;
- Stretchers;
- Disposable supplies;
- Normal waiting time; and
- Normal overhead costs of doing business.

What is not included in the base rate?

The base rate does not include the following:

- Mileage;
- Oxygen and oxygen administration;
- Extra attendant in specific circumstances (see page D.4); and
- Waiting time beyond the first 30 minutes.

Noncovered Ambulance Services

● MAA does not cover the following:

✓ Transport determined not to be medically necessary;
✓ Transport to a funeral home, mortuary, or morgue;
✓ Transport by non-certified services (e.g., wheelchair vans, Ambo cabs, etc.);
✓ Transport to non-appropriate facilities;
✓ Transport beyond nearest appropriate facility;
✓ Transport for the convenience of the client and/or family (e.g., preference to receive treatment from a particular physician or specialist);
✓ Response when clients refuse to be transported;
✓ Any trip solely because the client has no other means of transportation; and
✓ Ambulance transports to certain destinations:

➢ **Home -** MAA does not cover ambulance transports home, except when "home" is a nursing facility and the client needs to be transported in a prone or supine position. Claims submitted for transports from the hospital, skilled nursing facility, nursing home, or hospice should reflect the reason(s) why the client could not have gone home by any other means without endangering his/her health. Ambulance transports in such cases must be prior authorized by MAA and are evaluated on a case-by-case basis.

➢ **Hospital to Hospital -** Example of transports that are not payable:

✦ Doctor's preference (e.g., the client's primary physician practices at receiving hospital);
✦ Client's preference (e.g., to be closer to home or family);
✦ Evaluation and treatment of a client at another facility when inpatient status is maintained at originating hospital;
✦ Back door to front door transports within the same hospital complex; and
✦ Transports to meet insurance requirements or hospital/insurance agreements.

In general, for MAA to pay for a hospital-to-hospital ambulance transport, the client must have been discharged from the first hospital. MAA does not pay separately for transporting inpatients to and from another facility for diagnostic or therapeutic services without being discharged from the first hospital.

> **24 Hour walk-in clinics, Urgent Care Centers, Free Standing Outpatient Facilities and Physician's Office –** An Emergency Department is defined as an organized hospital-based facility that is open 24 hours a day. MAA considers 24-hour walk-in clinics and Urgent Care Centers as physician-based or physician-directed clinics. Like physician offices, they are not acceptable destinations for ambulance coverage, except under the following circumstances:

✦ Where stops are made at one of these entities in order to stabilize the client or because of a client's dire need for professional attention, **and immediately thereafter, the ambulance continues en route to the hospital**; or

✦ When a skilled nursing facility (SNF) or nursing home inpatient is transported roundtrip for specialized services to the nearest hospital or non-hospital treatment facility (e.g., clinic, therapy center, or physician's office) to obtain necessary diagnostic and/or therapeutic services (such as CT scan or radiation therapy) **not available** at the institution where the client is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the client is less costly than bringing the service to the client.

✦ MAA does not cover ambulance transports to a physician's office for evaluation and management services **in the absence of any specialized services** (i.e., tests or procedures that could not be brought to the client).

● MAA does not cover ambulance services if:

✓ The trip is a routine trip to return the client home from the hospital; or

✓ The client is transported from home or a nursing home to the hospital outpatient department or other treatment/diagnostic facility for treatment that could have been performed in the client's home or nursing home.

☞ **Note:** If a client is being discharged from a hospital to a qualified rehabilitation facility, MAA covers and separately reimburses the medically necessary transport of the client to the rehabilitation facility.

What records must be kept?
[Refer to WAC 388-502-0020 and WAC 388-546-0300]

The transportation provider must keep sufficient documentation to justify decisions about destination and type of transport for each client. The documentation must be legible, accurate, and complete. The documentation must be authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but is not limited to, the following information:

- Date(s) and time of service.
- Transported client's name and date of birth.
- Name(s) and title of person(s) performing service(s).
- Medical justification for each transport (e.g., suspected heart attack)
- Pertinent medical history.
- Pertinent findings on examination (e.g., will require medical attention en route)
- All medications and/or equipment/supplies provided.
- Description of treatment/medical intervention(s) (when applicable)
- Specific location of pick-up and destination and any additional or non-scheduled destinations (e.g., intermediate stop at physician's office to stabilize client). Origin information must include the facility's full name and address, including state. Destination information must include the facility's full name and address, including state.
- Beginning and ending instrument readings (air ambulance) for the trip.
- If air transportation is necessary to bypass the Washington State ferry system, this must be clearly documented, including the reasons why the ferry would be inadequate in any particular case.

Providers must make charts and records available to DSHS, its authorized contractors, and the US Department of Health and Human Services, upon their request. Providers must keep charts and records <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.

> **A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (Refer to WAC 388-502-0020[2])**

Documentation must show that clients are being triaged in a manner that ensures prompt access to appropriate care (i.e., to a facility best able to provide the level of care appropriate to a client's injuries and/or medical needs). The ambulance provider's Medical Control must consider the following in directing the client's transport to a treatment facility:

- The availability of special regional resources such as:

  - ✓ Trauma centers;
  - ✓ Burn centers; and
  - ✓ Toxicology treatment centers;

- The presence of regional health care networks;
- The existence of physician to physician relationships; and
- The availability of care at the destination hospital.

Quality of Care Audits and Reviews
[Refer to WAC 388-550-2541]

- MAA conducts prepayment and/or post payment reviews. Based on national and local medical policies, MAA selects providers demonstrating aberrant billing patterns for these reviews. MAA conducts these post payment reviews using the national and local policies effective when claims were processed. MAA requests refunds for any services that were not medically necessary based on these policies.

- To ensure quality of care, MAA may conduct an on-site review of any ambulance facility. See WAC 388-501-0130, Administrative Controls, for additional information on audits conducted by department staff.

Reasons for Recoupment

Ambulance operators must comply with all MAA published rules and billing instructions. MAA will recoup reimbursements made to providers if, among other reasons, it finds providers to be out of compliance with MAA rules and billing instructions. A paid claim does not mean the item or service is a covered benefit.

> ☞ **Please Note:** MAA requires providers to document why an ambulance was the only appropriate and effective means of transportation without further endangering the client's health. Please ensure that proper documentation is included in the client's file.

General Limitations to Payment for Ambulance Services

- Payment for ambulance services provided to an eligible client will be made on the basis of usual and customary charges or the rates established by MAA, whichever is lower. If there is a known third-party liable for payment, the provider must bill that party before billing MAA.

- MAA will not pay fee-for-service for ambulance transportation services provided to a client enrolled in a department-contracted, prepaid health plan. Payment in such cases is the responsibility of the plan.

- Mileage for covered transports will be paid only from the client's point of origin to the point of destination.

Ground Ambulance

Levels of Transporting Service

MAA reimburses for two levels of medically necessary ground ambulance transportation: Basic Life Support (BLS) and Advanced Life Support (ALS).

- A **BLS** transport is one in which the client:

    - ✓ Requires and receives basic services en route, such as control of bleeding, splinting of fracture(s), treatment for shock, and cardiopulmonary resuscitation; or

    - ✓ Needs to be transported in a prone or supine position, with or without medical services en route.

- An **ALS** transport is one in which the client requires and receives more complex services en route, such as:

    - ✓ Intravenous therapy;

    - ✓ Airway intubation;

    - ✓ Heart defibrillation by paramedics or other ALS-qualified personnel on-board a properly-equipped vehicle; or

    - ✓ Initiation of treatment for pneumothorax conditions.

Ground Ambulance Coverage

MAA covers ground ambulance transport to and from medical services.

☞ **Please Note:** In certain situations ambulance transport is included in bundled payments to hospitals or other providers. Payment for such inpatient transport is included in the hospital's Diagnosis Related Group (DRG) payment. In such a case the ambulance provider may not bill MAA or MAA's client for the transport. The hospital is responsible for the reimbursement of the ambulance transport.

● **Base Rate/Mileage**

✓ When a provider transports more than one client at a time to the same destination in the same ground ambulance, the provider must bill MAA:

➢ At the additional client base rate (BLS or ALS) for the additional client;
➢ No mileage charge for the additional client; and
➢ Using a separate HCFA-1500 claim form for each client and using modifier GM to indicate multiple patients on one ambulance trip.

✓ The base rate billed for each transport must reflect the level of care and types of medical interventions by trained and certified personnel on-board. MAA classifies a ground ambulance transport as BLS even with paramedics or ALS-qualified personnel on board if no ALS-type interventions are provided en route. Medical necessity, **not the level of personnel on board an ambulance**, dictates which level (BLS or ALS) of ground ambulance service is billed to MAA.

For example: A client with an IV is transported from the hospital to a nursing facility. Hospital staff set up and started the IV administration. The ambulance personnel provided no other interventions except to monitor the client during the transport. This transport qualifies only for the BLS base rate.

✓ Providers may bill for ALS return pickup or second ALS transport only when all of the conditions for an ALS transport are met (i.e., when ambulance personnel **perform** ALS-level interventions). Otherwise, the BLS base rate applies.

✓ MAA pays ground ambulance providers the same reimbursement rate per mile, regardless of the level of service.

✓ When billing for mileage, providers must bill MAA only for mileage calculated from the client's *point of pickup* to the *nearest appropriate point of destination.*

- **Oxygen, Medical Equipment, and Supplies**

  ✓ To bill more than one hour of oxygen (procedure code A0422), include justifying documentation (e.g., transport from Spokane to Harborview) with the claim for review. One unit = one hour of oxygen. Enter units in box 24G and transport origin and destination in box 19 of the HCFA-1500 claim form.

  ✓ MAA reimburses providers only for oxygen and intravenous supplies and administration. Reimbursement will be the provider's usual and customary charge or MAA's maximum allowable fee -- whichever is less. All other equipment and supplies are included in the base rate. **The need for billed supplies must be clearly documented in the client's file.**

  ✓ When the hospital provides equipment, supplies, and staff, the ambulance provider may <u>not</u> bill for those services.

- **Waiting Time**

  ✓ MAA has established rates taking into consideration that transporting a client often involves some waiting time. This waiting time (procedure code A0420) is <u>not</u> billable unless the waiting time is over 30 minutes and constitutes unusual circumstances. The claim must document the reason why the ambulance was required to wait and the exact amount of time involved.

  ✓ Include the same documentation in the client's file.

  ✓ **MAA does not reimburse for waiting time when the wait is related to a return pickup or second trip for the same client.**

  ✓ When waiting time is justified, procedure code **A0420** is reimbursed at a per-minute rate after the first 30 minutes. MAA will <u>not</u> reimburse for the first 1/2 hour (30 minutes) of waiting time.

    For example: If the total waiting time is 60 minutes aggravated by a ferry delay, bill A0420 with the number of minutes of service minus the first 30 minutes (one minute = one unit). Bill a 90-minute wait as 60 units (90 - 30 = 60 minutes). Enter units in field 24G on the HCFA-1500 claim form.

- **"No Transport Calls"**

    ✓ MAA does not reimburse providers if no transport occurs and the client dies:

    ➢ Before the ambulance arrives at the scene; or
    ➢ After the ambulance arrives at the scene, but before medical intervention is provided.

    ✓ When an ambulance provider provides medical services to a client at the scene, but the client dies before transport is made, then the **appropriate** <u>**BASE RATE**</u> applies, commensurate with the level of service provided. Providers must document in their files what medical interventions were provided to the client by the ambulance crew at the scene before the client died.

- **Ferry Tolls**

    MAA reimburses for ferry tolls incurred when transporting MAA clients. The provider must provide proper documentation of tolls incurred.

- **Other Professional Services**

    MAA includes professional services performed by a registered nurse (RN) or a physician in the base rate reimbursement. **MAA makes NO separate payment for professional services.**

- **Extra Attendant**

    In most situations, the base rate includes personnel charges. Therefore, an extra attendant is not paid separately. However, in the following situations, an additional payment for an extra attendant may be allowed when the need for those services is documented. Justification for an extra attendant would be:

    ✓ Client violent or difficult to control;
    ✓ More than one client requiring monitoring or medical attention being transported;
    ✓ Client weighs 300 pounds or more; or
    ✓ Transport of an Involuntary Treatment Act (ITA) patient requiring ambulance level services.

    When billing MAA, the provider must send justification of the unusual circumstance that warranted the need for an extra attendant.

    > **For example:** A suspected heart attack client in most cases would not be viewed as unusual or require or warrant the need for an extra attendant. If the suspected heart attack client is extremely obese or mentally disturbed, an extra attendant may be warranted provided documentation clearly indicates the **need** for such services.

Modifiers

The following origin and destination modifiers are single-digit modifiers used in combination. The first digit indicates the transport's place of origin. The destination is indicated by the second digit. You must enter these modifiers in field 24D on the HCFA-1500 claim form.

Providers must use a combination of **two digits** to identify origin and destination (e.g., A0428 NH, A0425 NH):

> ☞　　**Note:** Complete addresses for origin and destination must be kept in the client's file and available for review.

D	Diagnostic or therapeutic site other than "P" or "H" when used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at physician's office on the way to hospital

Providers must bill all services associated with the same ambulance transport using the same two-digit modifier. **In addition: If services are provided, but the client dies prior to transport, use modifier QL. Use the GM modifier, in addition to the two-digit destination modifier, for each additional client per transport.**

Fee Schedule

Modifiers required on all codes.
See *Modifiers, page D.5* for descriptions.

Basic Life Support (BLS)

ocedur de	Description	aximu llowal F
~~0002A~~	~~Basic Life Support (BLS), base rate, one way, one client.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0428 or A0429.**	~~$110.25~~
~~0004A~~	~~Basic Life Support (BLS) return pick-up or second BLS transport, same client, same 24-hour period (rate includes waiting time).~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0428 or A0429.**	~~$110.25~~
~~0003A~~	~~Basic Life Support (BLS), third transport, same client, same 24-hour period, justification required.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0428 or A0429.**	~~$110.25~~
~~0013A~~	~~Basic Life Support (BLS) services provided on scene, client dies before transport. Includes supplies used at scene, no mileage allowance.~~ *Discontinued for dates of service on and after October 1, 2003.* **Use A0429.**	~~$110.25~~
A0428	Ambulance service, basic life support, non-emergency (BLS). **Origin and destination modifiers required. Use modifier GM for each additional client.**	$110.33
A0429	Ambulance service, basic life support emergency transport (BLS-emergency) (rate includes supplies and waiting time). **Origin and destination modifiers required. Use modifier GM for each additional client.**	$110.33

Procedure Code	Description	Maximum Allowable Fee

Advanced Life Support (ALS)

0001A ~~Advanced Life Support (ALS), base rate, emergency transport, one way, one client.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0426, A0427, A0433, or A0434.** ~~$159.40~~

0015A ~~Advanced Life Support (ALS) return pickup or second ALS transport, same client, same 24-hour period (rate includes waiting time).~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0426, A0427, A0433, or A0434.** ~~$159.40~~

0014A ~~Advanced Life Support (ALS) services provided on scene, client dies before transport. Includes supplies used at scene, no mileage allowance.~~ *Discontinued for dates of service on and after October 1, 2003.* **Use A0427 or A0433.** ~~$159.40~~

A0426 Ambulance service, advanced life support non-emergency transport, level 1 (ALS 1). **Origin and destination modifiers required. Use modifier GM for each additional client.** $159.40

A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 emergency) (includes supplies and waiting time). **Origin and destination modifiers required. Use modifier GM for each additional client.** $159.40

A0433 Advanced Life Support (ALS), level 2, base rate, one way, one client. **Origin and destination modifiers required. Use modifier GM for each additional client.** $159.40

A0434 Specialty Care transport (includes supplies and waiting time). **Origin and destination modifiers required.** $159.40

Additional Client Base Rate

0005A ~~Emergency transport, base rate, each additional client, one way.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0427, A0429, or A0433, with modifier GM in addition to the origin and destination modifiers.** ~~$42.63~~

Procedure Code	Description	Maximum Allowable Fee

Additional Client Base Rate (cont.)

~~0006A~~	~~Emergency transport, base rate, return pickup or second transport, each additional client.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0427, A0429, or A0433, with modifier GM in addition to the origin and destination modifiers.**	~~$42.63~~

Mileage

~~0007A~~	~~Loaded mileage, one way, first passenger only, first trip.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0425.**	~~$4.50/mile~~
~~0008A~~	~~Loaded mileage, return pick-up or second trip same 24-hour period, one way, first passenger only.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0425.**	~~$4.50/mile~~
~~0016A~~	~~Loaded mileage, third transport, same client, same 24-hour period, justification required.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0425.**	~~$4.50/mile~~
A0425	Ground mileage, per statute mile. **Origin and destination modifiers required.**	$4.50/mile

Disposable Supplies

~~0010A~~	~~Oxygen supplies/administration, life-sustaining situation, per trip (all-inclusive fee; includes mask or cannula, and one hour of oxygen).~~ **~~Modifier Required.~~** ~~One unit = one hour of oxygen. Justification required more than one hour. See page D.3.~~ *Discontinued for dates of service on and after October 1, 2003.* **Use A0422.**	~~$17.28~~
~~0044A~~	~~IV supplies/administration (all-inclusive fee).~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0394.**	~~$7.45~~
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation. (All-inclusive fee, includes mask or cannula, and one hour of oxygen.) One unit = one hour of oxygen.	$17.28

Procedure Code	Description	Maximum Allowable Fee

Disposable Supplies (cont.)

A0394   ALS specialized service disposable supplies; IV drug therapy (all-inclusive fee). $7.45

Ferry Tolls

~~0009A~~   ~~Puget Sound ferry tolls, one way (inclusive of vehicle, driver, and passenger(s)).~~ **Modifier Required.** *Discontinued for dates of service on and after October 1, 2003.* **Use A0170.**   ~~$13.00~~

~~0018A~~   ~~San Juan Island ferry tolls, one way (inclusive of vehicle, driver, and passenger(s)).~~ **~~Modifier Required. Invoice Required~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0170.**   ~~By Report~~

A0170   Transportation ancillary; parking fees, tolls, other (**invoice required**) **Origin and destination modifiers required.**   By Report

Other Services

~~0011A~~   ~~Waiting time (justification required), loaded, allowed after first 30 minutes.~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0420.**   ~~$.63/min~~

A0420   Ambulance waiting time (ALS or BLS), one-half hour increments. (Allowed after first 30 minutes.)   By Report

~~0012A~~   ~~Extra certified/licensed attendant, justification required.*~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Use A0424.**   ~~$23.18~~

~~0020A~~   ~~Defibrillation, BLS trips only (included in ALS trips).~~ **~~Modifier Required.~~** *Discontinued for dates of service on and after October 1, 2003.* **Bundled into BLS base rate.**   ~~$31.74~~

Procedure Code	Description	Maximum Allowable Fee

Other Services (cont.)

A0424 Extra certified/licensed attendant, justification required.* **Origin and** $23.18
    destination modifiers required.

T2006 Response and treatment, no transport. (Code not payable. Used for data #
    collection purposes only.)

*Justification for Extra Attendant:

- When the client is violent or difficult to control;
- When there is more than one client requiring monitoring or medical attention being transported;
- Client weighs 300 lbs. or more; or
- Transport of ITA patient.

Air Ambulance

What is covered?

- MAA covers air ambulance transportation services, by either a helicopter or a fixed wing aircraft, when:

  - ✓ The vehicle and crew meet MAA's guidelines and requirements;

  - ✓ The destination is an acute care hospital; and

  - ✓ The client's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance, and:

    - ➢ The point of pickup is inaccessible by ground ambulance vehicle; or

    - ➢ Great distances and/or obstacles are involved in getting the client to the nearest hospital with appropriate facilities.

  The client's condition must be such that the time needed to transport by ground or the risk of transportation by ground poses a threat to survival or could seriously endanger the client's health.

- If the client is transported by air ambulance, but MAA determines that ground ambulance would have sufficed, MAA bases payment on the amount payable for ground transport, if less costly. Also, as with ground ambulance, if the transport was medically necessary, but the client could have been treated at a nearer hospital, the air transport payment is limited to the rate from the point of pickup to the closer hospital.

- MAA covers air ambulance transport for transfer of a client from one hospital to another when medically appropriate (e.g., transportation by ground ambulance would take too long and endanger the client's health). In these cases, the transferring hospital does not have adequate resources to provide the medical services needed by the client.

- Air ambulance operators may bill MAA for air mileage calculated from the client's point of pickup to the nearest appropriate point of destination only. The air ambulance operator must pay subsequent ground ambulance transportation (beyond air mileage) to the ground ambulance operator. MAA reimburses a lift-off fee for each client.

- If multiple transports are made on the same day, for the same client, every lift-off is a separate trip. Records must reflect why multiple trips have occurred on the same day.

Vendor Requirements

Air ambulance operators must:

- Be a participating Medicaid provider in at least one of the 50 states;

- Have signed a Washington State MAA core provider agreement; and

- Agree to accept MAA rates as payment in full.

Air Ambulance Services to Out-of-State Treatment

- MAA allows out-of-state transportation only when medical services have been prior approved by MAA as an exception to rule. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the out-of-state treatment to:

  > Division of Medical Management
  > (360) 725-1555 (phone)
  > (360) 586-1471 (fax)

- MAA considers the following criteria when reviewing a request for out-of-state services:

  - ✓ There is no equally effective, less costly alternative available in Washington State; and
  - ✓ The service/treatment is not experimental.

- If MAA authorizes the out-of-state treatment, and the client needs air ambulance services, request authorization for air ambulance transport. The request for an air ambulance may be made at the same time as the request for out-of-state treatment, but the requests are evaluated separately by MAA.

- If MAA authorizes the air ambulance transport for the out-of-state treatment, call the Rate Analysis Section at 360-725-1835 to arrange for the air ambulance transport.

- Air ambulance transports in these cases are reimbursed at negotiated rates. MAA payment is payment in full (see note on next page).

- MAA uses commercial airline companies when the client's medical condition allows the client to travel on a commercial flight.

Air Ambulance Services from Out-of-State Treatment to In-State Treatment

- MAA considers transports from out-of-state to in-state facilities on a case-by-case basis. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the in-state treatment to:

    Division of Medical Management
    (360) 725-1555 (phone)
    (360) 586-1471 (fax)

    After authorization is received from MAA for the transport to an in-state treatment facility, call the Rate Analysis Section at 360-725-1835 to arrange for air ambulance transport if air ambulance services are required.

- MAA uses commercial airline companies whenever the client's medical condition allows.

☞ **Please Note:** MAA holds air ambulance providers to the contractually agreed upon rate for each medically necessary, interstate air ambulance trip MAA prior authorizes. Therefore, providers should maintain close contact with the discharging and/or receiving facilities to ensure proper coordination of the client transfer process. MAA makes no additional payment to the air ambulance provider when the transport is rescheduled or re-routed.

☞ **Example:** When flying to another state to pick up a client, an air ambulance provider should maintain contact with the facility providing medical services to the client in case the client has a setback and is unfit for transport. This will help ensure that the provider does not reach the facility only to have to leave without the client and return later for pickup, thus being reimbursed for only one trip when two were made.

Fee Schedule

MAA assumes that all air transports are ALS, which is taken into consideration in the rates. There is no separate reimbursement for equipment and supplies such as incubators, dressings, or oxygen tanks. The base rate includes these costs.

Discontinued Procedure Code	New Procedure Code	Description	Maximum Allowable Fee
0503A	A0430	Ambulance service, conventional air services, transport one way (fixed wing) (per client transported)	$859.80
0504A	A0431	Ambulance service, conventional air services, transport one way (rotary) (per client transported)	$725.80
0510A	A0435	Fixed-wing air mileage, per statute mile (one way, per flight, equally divided by the number of clients transported)	$5.50/ air mile
0511A	A0436	Rotary air mileage, per statute mile (one way, per flight, equally divided by the number of clients transported)	$13.31/ air mile

☞ **Note:** MAA conducts post-pay reviews. Based on information available at the time of service, MAA may determine that ground ambulance transport would have been sufficient. If this happens, MAA pays the rate for ALS ground service, if less costly.

The need for air ambulance transport must be clearly documented in the ambulance provider's records.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- ### Initial Claims

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  ➢ The date the provider furnishes the service to the eligible client;
  ➢ The date a final fair hearing decision is entered that impacts the particular claim;
  ➢ The date a court orders MAA to cover the service(s) provided; or
  ➢ The date DSHS certifies a client eligible under delayed[2] certification criteria.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  ➢ DSHS certification of a client for a retroactive[3] period; or
  ➢ The provider proves to MAA's satisfaction that there are extenuating circumstances.

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2 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

3 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **<u>Resubmitted Claims</u>**

  Providers may **resubmit, modify, or adjust** any timely initial claim, <u>except</u> prescription drug claims, for a period of 36 months from the date of service. (Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.)

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time periods listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary charge.

When can I bill the client?

Please refer to MAA's <u>General Information Booklet</u> for information on billing the client or to WAC 388-502-0160.

How do I bill for services provided to PCCM clients?

When billing for services provided to clients with a Primary Care Case Manager (PCCM):

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for mileage?

- Bill mileage only from the client's point of pickup to the point of destination.

- If an air ambulance transports more than one client on a single trip, MAA will pay the lift-off rate for each client. If more than one client is served with a single transport, document each pick-up point, destination, number of air miles. The miles associated with the trip must be divided equally by the number of clients transported. Modifier GM is required to indicate multiple patients on one ambulance trip.

- For ground ambulance only, if the provider makes a second or third transport for the same client during the same 24-hour period, the client's file must document or the billing must indicate that it is a second or third transport, with appropriate pick-up and destination modifiers.

- For ground ambulance when more than one client is transported on the same trip, no mileage charge is payable for the additional client(s).

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage. Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

> ☞ **Note:** Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
>
> ☞ **Note:** A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MAA uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1)   The provider <u>accepts</u> assignment; and

2)   The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical ID card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder <u>before</u> adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

NOTE: Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a **B** in *field 19* to indicate the baby is on a parent's PIC.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, show the last name, first name, and middle initial of the insured. If the client has insurance that is secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

> **Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) NUMBER**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.- d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If *11d.* is left blank, your claim may be processed in error.

19. **Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.*

Medicare/Medicaid Eligible Clients: Also when applicable, enter *nonemergent* here when you are billing for a nonemergency service provided to a client whose physical condition was such that the use of any other transportation method was inadvisable.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) detail line per claim line (fields 24A - 24K). If you bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403).

24B. **Place of Service**: Required. Enter:

41   Ambulance, land
42   Ambulance, air

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies HCPCS/Modifier:** Required. Enter the appropriate procedure code for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*).

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. **Do not** include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the total number of mileage or service units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number:** **Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry *that you may use as your internal reference number*. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. **Do not** use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. **Do not** use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges **minus** any amount(s) in *field 29*. **Do not** use dollar signs or decimals in this field.

33. **Billing Name, Address, Zip Code, and Telephone #**: Required. Enter the provider's *Name, Address,* and *Telephone #* on all claim forms.

    Group: Enter your seven-digit provider number as assigned to you by MAA.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA | | | PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |___ . ___
2. |___ . ___
3. |___ . ___
4. |___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS · MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
From MM	DD	YY	To MM	DD	YY										
1															
2															
3															
4															
5															
6															

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# _____ GRP# _____

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE   MEDICAID   CHAMPUS   CHAMPVA   GROUP HEALTH PLAN   FECA BLK LUNG   OTHER

(Medicare #)   (Medicaid #)   (Sponsor's SSN)   (VA File #)   (SSN or ID)   (SSN)   (ID)

1a. INSURED'S I.D. NUMBER   (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY   SEX M □ F □

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self □ Spouse □ Child □ Other □

7. INSURED'S ADDRESS (No., Street)

CITY   STATE

8. PATIENT STATUS Single □ Married □ Other □

Employed □ Full-Time Student □ Part-Time Student □

CITY   STATE

ZIP CODE   TELEPHONE (Include Area Code) (   )

ZIP CODE   TELEPHONE (INCLUDE AREA CODE) (   )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES □ NO □

a. INSURED'S DATE OF BIRTH MM DD YY SEX M □ F □

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M □ F □

b. AUTO ACCIDENT?   PLACE (State) YES □ NO □

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES □ NO □

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES □ NO □ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES □ NO □ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |___.___   3. |___.___
2. |___.___   4. |___.___

22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN □ EIN □

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES □ NO □

28. $ TOTAL CHARGE   29. $ AMOUNT PAID   30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#   GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

> **The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.**

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD   DESCRIPTION

1a.   **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID card. This information consists of the client's:

a)   First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b)   Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c)   First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d)   An alpha or numeric character (tiebreaker).

For example:
1.   Mary C. Johnson's PIC looks like this: C010633JOHNSB.
2.   John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

> **Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. *Indicate the name of the coverage source in field 10d* (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

24B. **Place of Service**: Required. Enter:

    41   Ambulance, land
    42   Ambulance, air

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies HCPCS/Modifier**: Required. **Coinsurance and Deductible**: Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*).

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Units: Required. Multiple units valid only on Mileage and Waiting Time codes. For all other codes enter a "1".

24K. <u>Reserved for Local Use</u>: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. <u>Your Patient's Account No.</u>: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Numbe*r*.

27. <u>Accept Assignment</u>: *Required*. Check **yes.**

28. <u>Total Charge</u>: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. <u>Amount Paid</u>: Required. Enter the <u>Medicare Deductible</u> here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. <u>Balance Due</u>: Required. Enter the <u>Medicare Total Payment</u>. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. <u>Name and Address of Facility Where Services Are Rendered</u>: Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. <u>Billing Name, Address, Zip Code, and Telephone #</u>: Required. Enter the provider's *Name, Address,* and *Telephone #* on all claim forms.

<u>**Group:**</u> Enter your seven-digit provider number as assigned to you by MAA.

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA | | | PICA | | |

PATIENT AND INSURED INFORMATION

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY   SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS)
YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY   SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY   SEX M ☐ F ☐

b. AUTO ACCIDENT?   PLACE (State)
YES ☐ NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY   MM DD YY
FROM   TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY   MM DD YY
FROM   TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES ☐ NO ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |___|.|___| 3. |___|.|___|

2. |___|.|___| 4. |___|.|___|

22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A					B	C	D		E	F	G	H	I	J	K
	DATE(S) OF SERVICE					Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	From MM DD YY			To MM DD YY												
1																
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER   SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#   GRP#

APPROVED OMB-0938-0008

CARRIER

| | PICA | | **HEALTH INSURANCE CLAIM FORM** | PICA | |

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER   (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY   STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY   STATE

ZIP CODE   TELEPHONE (Include Area Code) (   )

ZIP CODE   TELEPHONE (INCLUDE AREA CODE) (   )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS)
YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT?   PLACE (State)
YES ☐ NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES ☐ NO ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. |____.__   3. |____.__
2. |____.__   4. |____.__

22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A			B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From MM DD YY	To MM DD YY											
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#   GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500